PostScript

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Perianal verrucous epidermal naevus mimicking perianal warts

A case of perianal verrucous epidermal naevus mimicking perianal warts in a 2 year old boy is described. Verrucous epidermal naevus should be included in the differential diagnosis of perianal warty lesions, particularly when they are present since birth or appear during childhood.

CASE REPORT

A 2 year old boy was referred by a paediatrician for the evaluation of a perianal verrucous lesion which looked like perianal warts. The condition was first noticed by the child's mother when he was 9 months old as a raised velvety area around the anal orifice. Over the next few months, multiple, small, warty elevations developed over the region. The lesions had remained stable thereafter. There was no parental report of scratching, exudations or bleeding, or difficulty in passing stools. There was no history of viral warts or any STD in the parents. The child has remained in good health since his birth and achieved the milestones normally. Examination revealed a mildly elevated, velvety, periorificial skin studded with multiple, brownish, keratotic papules (fig 1).

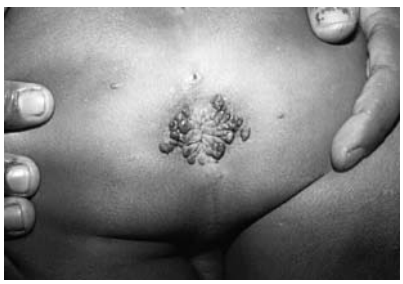

Figure 1 Perianal warty papules.

Detailed systemic examination failed to reveal any abnormality.

A provisional diagnosis of verrucous epidermal naevus was made and a punch biopsy specimen was obtained. Histological examination corroborated the clinical diagnosis by showing hyperkeratosis, acanthosis, and papillomatosis without any evidence of vacuolar change in the keratinocytes or any dermal pathology. Virological study for human papillomavirus (HPV) could not be done owing to lack of facilities. The parents declined any immediate treatment for the asymptomatic condition and during a follow up period of 1 year, the child has remained healthy with the lesions remaining unchanged in appearance.

COMMENT

Verrucous epidermal naevi are circumscribed hamartomatous lesions composed almost exclusively of keratinocytes.[1] Most epidermal naevi usually occur at birth or infancy but rarely their appearance may be delayed until puberty.[2] The lesions typically consist of closely set warty papules that coalesce to form well defined keratotic plaques usually in a linear fashion. Verrucous epidermal naevi may be almost of any size, may be single or multiple, and can occur at more or less any site.[1] Since these lesions closely mimic viral warts, their occurrence in the perianal region during childhood or adolescence may raise the suspicion of perianal warts as in the present case. Onset of the lesions early in life, their stable nature, typical linear configuration, and histological features may help in the differential diagnosis. Usually only of cosmetic importance, the skin lesions may be treated by cryotherapy, surgical excision, or carbon dioxide laser ablation.[1 3]

Epidermal naevi, particularly if extensive, may be associated with other developmental anomalies mainly involving the central nervous system, the skeletal system, and the eyes.[4] In a large study, one or more such abnormalities were demonstrated in 33% of cases.[2] Since patients with epidermal naevi are at significant risk of having other abnormalities, detailed systemic examination and periodic follow up is warranted in every case to exclude them.

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Accepted for publication 29 May 2003

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Investigating the microbial aetiology of pelvic inflammatory disease

An effort to elucidate a subject which is laden with difficulties is noteworthy, so that it was interesting to read the report by Simms *et al*[1] on the associations between *Mycoplasma genitalium*, *Chlamydia trachomatis*, and pelvic inflammatory disease (PID). The difficulties are at least threefold. Firstly, a diagnosis of PID based on symptoms and clinical signs, as in the study reported, is acknowledged, both generally and by the authors, to be imprecise. Clinical observations often do not tally with laparoscopic findings,[2] laparoscopy being a fundamental diagnostic requirement in research investigations. Secondly, it is obvious that specimens cannot be taken from the inflamed site in question without laparoscopy. Indeed, it is axiomatic that this should be done if there is to be any chance of unravelling the microbial aetiology. Taking specimens from the cervix is very much second best as the results of microbiological testing may bear no relation to the pathological changes in the tubes. Thirdly, and no less relevant, is the question of an adequate control group. It seems that this should not comprise women undergoing tubal ligation. Although a source of normal tubes would seem sensible, the women were not in the same cohort as those with disease and, in any event, for comparative purposes specimens were taken from the cervix. Surely, an examination of specimens from women without symptoms and signs of PID but who were otherwise comparable to those who did have symptoms and signs would have been more appropriate? In future investigations, controls should be women within a laparoscopically based study who are found not to have PID on laparoscopy. Even then, the situation may be clouded because, in one study,[3] *C trachomatis* was detected as often in the tubes of women who did not have PID visually as in those of women who did. Certainly, however, finding *M genitalium* in the cervix of women with ill defined PID significantly more often than in the cervix of women who did not have PID and who, in other ways, appeared not to be comparable may mean nothing in relating *M genitalium* to tubal pathology. It is a far cry from unravelling the role of *M genitalium* in PID, despite some strong suggestions that it might be involved.[4]

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Accepted for publication 9 May 2003

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